TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
SOUTH TEXAS RADIOLOGY GROUP

Respondent Name
SOUTHWESTERN BELL TELEPHONE LP

MFDR Tracking Number
M4-16-3313-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
JUNE 28, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We originally sent our bills to Liberty Mutual…as this is what was provided at the time of service. We then called for claim status & we were told no claim on file & we were told we have the incorrect claims mailing address…Per 28 TAC 133.20 we have 95 days to submit a claim once we became aware of new insurance information if we have previously billed a Work Comp or Commercial Insurance."

Amount in Dispute: $77.64

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Requestor's documentation shows they submitted their medical bill to Liberty Mutual. However, Liberty Mutual is not the correct third party administrator (TPA) for the insurance carrier. Requestor was well aware Sedgwick CMS was the correct TPA. This is shown in a previous medical fee dispute case under M4-16-1384-01. In that case, Requestor had received EOBs and other information indicating Sedgwick CMS was the correct TPA for this injured employee's [date of injury] claim. See page 27 of the DWC-60. Requestor received this information prior to the date of service at issue in this matter. The documentation in M4-16-1384-01 9thr prior dispute0 clearly shows Requestor sent their request for reconsideration to Sedgwick CMS at the correct address. Therefore, Requestor knew to send medical bills to Sedgwick CMS on this claim…Sedgwick CMS first received the medical bill on 2/5/16 which was more than 95 days after the date of service."

Response Submitted by: Downs Stanford, PC

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 26, 2015	CPT Code 72131-26 Professional Component for CT Lumbar Spine w/o Contrast	$77.64	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. Texas Labor Code §408.027, effective September 1, 2007, sets out the rules for timely submission of a claim by a health care provider.
2. Texas Labor Code §408.0272, effective September 1, 2007, provides for exceptions for timely submission of a claim by a health care provider.
3. The services in dispute were reduced / denied by the respondent with the following reason codes:
   - 29-The time limit for filing claim has expired.
   - 937-Service(s) are denied based on HB7 provider timely filing requirement. A provider must submit a medical bill to the insurance carrier on or before the 95th day after the date of service.

Issues

Did the requestor support position that the disputed bills meet exception for filing timely?

Findings

Texas Labor Code §408.027(a) states, "A health care provider shall submit a claim for payment to the insurance carrier not later than the 95th day after the date on which the health care services are provided to the injured employee. Failure by the health care provider to timely submit a claim for payment constitutes a forfeiture of the provider's right to reimbursement for that claim for payment."

Texas Labor Code §408.0272(b)(1) states "Notwithstanding Section 408.027, a health care provider who fails to timely submit a claim for payment to the insurance carrier under Section 408.027(a) does not forfeit the provider's right to reimbursement for that claim for payment solely for failure to submit a timely claim if: (1) the provider submits proof satisfactory to the commissioner that the provider, within the period prescribed by Section 408.027(a), erroneously filed for reimbursement with: (A) an insurer that issues a policy of group accident and health insurance under which the injured employee is a covered insured; (B) a health maintenance organization that issues an evidence of coverage under which the injured employee is a covered enrollee; or (C) a workers' compensation insurance carrier other than the insurance carrier liable for the payment of benefits under this title."

According to the explanation of benefits, the respondent denied reimbursement for the disputed service, CPT code 72131-26, based upon "29-The time limit for filing claim has expired."

The requestor claims reimbursement is due because "We originally sent our bills to Liberty Mutual…as this is what was provided at the time of service. We then called for claim status & we were told no claim on file & we were told we have the incorrect claims mailing address…Per 28 TAC 133.20 we have 95 days to submit a claim once we became aware of new insurance information if we have previously billed a Work Comp or Commercial Insurance."

The respondent maintains the denial of reimbursement in the position summary stating "Requestor was well aware Sedgwick CMS was the correct TPA. This is shown in a previous medical fee dispute case under M4-16-1384-01. In that case, Requestor had received EOBs and other information indicating Sedgwick CMS was the correct TPA for this injured employee's 10/8/1998 claim. See page 27 of the DWC-60."

The respondent submitted a copy of a letter from requestor to Sedgwick dated October 19, 2015 requesting reconsideration of a bill for care rendered to claimant; therefore, the respondent supported position that the requestor was aware of the correct insurance carrier information prior to the disputed date of service. The Division finds that the requestor did not support position that they meet the exception for past due filing deadline per Texas Labor Code §408.0272(b)(1). As a result reimbursement is not recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is not due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		09/02/2016
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.